Important Telephone Numbers

The table below lists frequently used services and their telephone numbers. You may obtain recipient information and ask questions by utilizing these services.

Service	Information available	Telephone number	Hours
Automated Voice Response (AVR) System (Recorded information)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247	24 hours/7 days a week
Commercial Eligibility Software and Forward Card Magnetic Stripe Readers	Recipient Eligibility*	Call Provider Services for a list of software and card reader vendors.	24 hours/7 days a week
Provider Services (Correspondents)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/eligibility/ billing: 8:30-4:30 (M, W-F) 9:30-4:30 (T) Pharmacy: 8:30-9:00 (M, W-F) 9:30-9:00 (T) 9:00-5:00 (Sat.)
Direct Information Access Line with Updates for Providers (Dial-Up)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 if you would like more information.	7:00-6:00 (M-F)

*Recipient eligibility information includes:

- Lock-in status.
- Medicare coverage.
- Medicaid managed care program name and telephone number.
- Privately-purchased managed care or other commercial health insurance coverage.
- Limited benefit information.

Order Form

Use this form to order additional complete copies of the Personal Care Handbook or separate handbook sections. You may also use this form to order a three-ring binder to hold your handbook(s).

Handbook Name	Quantity	Amount	Total
Personal Care Handbook, complete set		$34.50	
General Information section		$ 7.00	
Covered Services section		$ 6.25	
Prior Authorization section		$11.75	
Billing section		$ 9.50	
Wisconsin Medicaid Binder		$ 5.00	
Subtotal			$_____
5% Sales Tax			$_____
1/2% County Sales Tax (if applicable)			$_____
TOTAL ENCLOSED			$_____

If applicable, tax exempt number: _____

Company or organization: _____
Mailing address: _____
_____
Contact person: _____
Telephone number: _____

Send this form and a check or money order (made payable to EDS) for the full amount, including sales tax, to:
Medicaid Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Download Medicaid handbooks from the web

Wisconsin Medicaid handbooks are also available on the Internet. To download this handbook or its sections free of charge from the worldwide web, visit the Handbooks area of the Provider Publications section of the Medicaid web site at *www.dhfs.state.wi.us/medicaid*.

Ordering Wisconsin State Statutes & Wisconsin Administrative Code

You may purchase a copy of HFS 101-108, Wis. Admin. Code, and Wisconsin State Statutes from the address or telephone number at right.

To order from Document Sales:

Write:
Document Sales
Integrated Document Services
Department of Administration
P.O. Box 7840
Madison, WI 53707

Or call:
(608) 266-3358

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Preface

The Wisconsin Medicaid Personal Care Handbook is issued to personal care providers who participate in Wisconsin Medicaid. It contains information that applies to *fee-for-service* Medicaid providers. The information in this handbook applies to services provided to both Medicaid and BadgerCare recipients.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. BadgerCare extends Medicaid coverage to uninsured children and parents with incomes below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in Medicaid HMOs are entitled to at least the same benefits as Medicaid fee-for-service recipients; however, HMOs may establish their own requirements regarding coverage limitations, prior authorization, billing, etc. If you are a Medicaid HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used to resolve disputes regarding covered benefits under managed care arrangements.

The Personal Care Handbook consists of the following sections:

- General Information.
- Covered Services.
- Prior Authorization.
- Billing.

In addition to the Personal Care Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following subjects:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.
- Response to Claims Submission.

The Provider Rights and Responsibilities section of the All-Provider Handbook identifies specific responsibilities of a Wisconsin Medicaid provider. Refer to this section for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

Important:
The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Wisconsin regulation and law

- Regulation: Wisconsin Administrative Code, Rules of Health and Family Services, Chapters HFS 101 - 108.
- Law: Wisconsin Statutes: Sections 49.43 - 49.497 and 49.665.

Federal regulation and law

- Regulation: Title 42 CFR Parts 430 - 456 -- Public Health.
- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.

Wisconsin Medicaid handbooks and updates further interpret and implement these laws and regulations.

Wisconsin Medicaid handbooks and updates, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information are available at Wisconsin Medicaid's web site at: *www.dhfs.state.wi.us/medicaid*.

The DHFS contracts with a fiscal agent to provide health claims processing, communications, and other related services.

General Information

Prior authorization (PA) is approval of coverage of Wisconsin Medicaid services granted by the Department of Health and Family Services (DHFS) before the provision of the services.

If the provider delivers a service that requires PA without first obtaining PA, the *provider* is *solely* responsible for the cost of the service.

- Prior authorization does not guarantee reimbursement. Refer to the Billing section of this handbook for more information on reimbursement.
- If the provider delivers a service that requires PA without first obtaining PA, the *provider* is *solely* responsible for the cost of the service, according to HFS 107.02(3)(c), Wis. Admin. Code. The provider may not bill the recipient or his or her family, according to HFS 106.02(11).
- HFS 107.02(3), Wis. Admin. Code, provides the DHFS with authority to require PA for covered services. It also provides procedures for PA documentation and departmental review criteria used to authorize coverage and reimbursement.

Reasons for Prior Authorization

According to HFS 107.02(3)(b), Wis. Admin. Code, PA procedures are designed to:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payment.
- Assess the quality and timeliness of services.
- Determine if less expensive alternative care, services, or supplies are usable.
- Promote the most effective and appropriate use of available services and facilities.
- Curtail misutilization practices of providers and recipients.

Additional Prior Authorization Information

More information about the following PA issues can be found in the All-Provider Handbook, including:

- Provider responsibilities.
- Prior authorization for emergency services.
- Recipient retroactive eligibility.
- Recipient appeal rights.
- Prior authorization for out-of-state providers.

DHFS Review Criteria for Prior Authorization

According to HFS 107.02(3)(e), Wis. Admin. Code, the DHFS considers the following in determining whether to approve or disapprove a request for PA:

- The medical necessity of the service, as defined in HFS 101.03(96m), Wis. Admin. Code.
- The appropriateness of the service.
- The cost of the service.
- The frequency of furnishing the service.
- The quality and timeliness of the service.
- The extent to which less expensive alternative services are available.
- The effective and appropriate use of available services.
- The misutilization practices of providers and recipients.
- The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare or private insurance guidelines.
- The need to ensure that care of unacceptable quality receives closer professional scrutiny.

- The flagrant or continuing disregard of established state and federal policies, standards, fees, or procedures.
- The professional acceptability of unproven or experimental care, as determined by DHFS consultants.

Prior Authorization Does Not Guarantee Reimbursement

Prior Authorization is one step in determining whether Wisconsin Medicaid will reimburse a covered service. Provider certification, recipient eligibility, and medical necessity, as well as all other state and federal requirements, must be met before reimbursement is made by Wisconsin Medicaid according to HFS 107.02(3)(i), Wis. Admin. Code.

Provider certification, recipient eligibility, and medical necessity, as well as all other state and federal requirements, must be met before reimbursement is made by Wisconsin Medicaid.

Change of Provider

Personal care PAs may not be transferred from one provider to another, according to HFS 107.02(3)(g), Wis. Admin. Code. When a new provider takes over personal care services for a Medicaid recipient, that provider is required to submit a new PA request form for that recipient with all attachments included. The original provider must also amend its PA to end on date of discharge. Refer to the Amending an Approved Prior Authorization portion of this section for more information on amending approved PAs.

Change or End of Ownership

When an agency goes out of business, it is required to submit PA amendments to discontinue all active PAs, indicating the recipient's last date of service. Refer to the All-Provider Handbook for detailed information on voluntary termination of Wisconsin Medicaid participation.

Services Requiring Prior Authorization

Personal Care Services

Prior authorization (PA) is required in the following circumstances:

- All personal care services that exceed 50 hours per calendar year, per recipient, according to Wisconsin Act 27, Laws of 1995, the biennial budget.
- All personal care hours when provided to a recipient who is also receiving private duty nursing (PDN) or respiratory care services (RCS), according to HFS 107.02(3)(e) and HFS 101.03(96m), Wis. Admin. Code.

Since it may be difficult for you to determine if another provider has already provided care, you are encouraged to obtain PA as soon as possible.

The 50-Hour Prior Authorization Threshold

In each calendar year, Wisconsin Medicaid allows a recipient to receive up to 50 hours of medically necessary personal care services in any combination of prior authorized or non-prior authorized hours. Once Wisconsin Medicaid has reimbursed 50 hours of personal care services or travel time in a calendar year, all subsequent hours must have PA. This is called the 50-hour PA threshold and allows sufficient time for a PA request to be processed and for providers to coordinate care if necessary. The 50-hour PA threshold is per recipient, *not* per provider.

Services That Count Toward the 50-Hour Prior Authorization Threshold

Services that count toward the 50-hour PA threshold are:

- All reimbursed personal care worker (PCW) and travel time services, whether or not the services have PA.
- The aggregate hours of PCW and travel time service for a recipient by all providers. Since it may be difficult for you to determine if another provider has already provided care, you are encouraged to obtain PA as soon as possible.

Example of the 50-hour PA threshold: You receive PA and begin providing personal care on January 1. If you submit a claim with a PA number in January for 50 hours and then subsequently submit a claim for 10 hours without PA, the claim for 10 hours will be denied because the 50-hour PA threshold has already been met.

Services That Do Not Count Toward the 50-Hour Prior Authorization Threshold

Services that do not count toward the 50-hour PA threshold are:

- Personal care supervisory visits, which do not require PA.
- Home health services, such as home health aide services, which have separate PA requirements. Refer to the Home Health Handbook for these requirements.

Important Guidelines Regarding the 50-Hour Prior Authorization Threshold

Some important guidelines regarding the 50-hour PA threshhold are:

- Once Medicaid has reimbursed 50 hours of personal care or travel time for a recipient in a calendar year, all subsequent personal care services require PA.
- Medicaid will not backdate a PA due to a provider's failure to monitor the number of hours of personal care provided.
- Claims for services beyond the 50-hour PA limit will be denied if there is no PA.
- Because the number of hours that can be provided before PA is required is limited, the provider should:
  - √ Request PA for a recipient when the initial Plan of Care (POC) is completed.
  - √ Coordinate services with other agencies in situations of case sharing

because services by all providers count toward the 50-hour limit.

√ Request subsequent PAs before the current PA expires to avoid a lapse in service. Renewal PAs will not be backdated.

Disposable Medical Supplies

Prior authorization is only required if the quantity of medically necessary disposable medical supplies (DMS) requested is greater than the allowed quantity as listed in the DMS Index. Some supplies are included in the reimbursement rate and are not separately reimbursable. Refer to the Covered Services section of this handbook for more information on DMS. Providers should consult their current Medicaid DMS Index for PA information and information on supplies included in the home health reimbusrement rate.

Prior authorization is only required if the quantity of medically necessary disposable medical supplies (DMS) requested is greater than the allowed quantity as listed in the DMS Index.

Requesting Prior Authorization

To obtain prior authorization (PA) for personal care services and disposable medical supplies (DMS), providers are required to submit certain documents that accurately and completely demonstrate the need for the service.

To obtain prior authorization (PA) for personal care services and disposable medical supplies (DMS), providers are required to submit certain documents that accurately and completely demonstrate the need for the service. If the documentation contains errors or is incomplete, approval of the PA will be delayed while the request is returned to the provider to supply the required information.

Prior Authorization for Personal Care Services

Required Prior Authorization Forms

Providers are required to submit the following PA documents to Wisconsin Medicaid:

The Wisconsin Medicaid Home Care Assessment Form or Update Form

- All new PA requests must be accompanied by the Wisconsin Medicaid Home Care Assessment Form. Refer to Appendix 1 of this section for instructions on how to complete the Wisconsin Medicaid Home Care Assessment Form and Appendix 2 for a Wisconsin Medicaid Home Care Assessment Form which may be photocopied.
- All PA renewals or amendments are required to have either a new Wisconsin Medicaid Home Care Assessment Form or a Wisconsin Medicaid Home Care Assessment Update Form. Refer to Appendix 3 for a Wisconsin Medicaid Home Care Assessment Update Form, which may be photocopied.

The Physician's Orders

- Providers are required to send copies of written physician's orders with all PA requests. However, providers have the option of using either a written physician prescription or the HCFA 485 Plan of Care (POC) and HCFA 487 forms for physician's orders. Orders presented on the HCFA 485/487 may help you submit a more complete PA request and decrease the number of PAs returned for incomplete information. The HCFA 486 contains data which is often essential for determining the medical necessity of care ordered in the HCFA 485. Refer to Appendix 4 for instructions on completing HCFA forms 485, 487, and 486. Refer to appendices 5 through 7 for the HCFA 485, 486, and 487 forms, which may be photocopied.
- The PA request may be sent to Wisconsin Medicaid before obtaining the physician's signature on the physician's orders. However, providers are required to:
  - √ Clearly indicate the attending physician's name and address on the orders accompanying the PA request.
  - √ Obtain dated and signed physician orders within 20 days of the issuance of the order and keep on file in the recipient's medical record.
  - √ Obtain physician's orders for ongoing cases before the previous orders expire. Services provided without properly documented orders are subject to recoupment.

Licensed home health agencies should refer to the Additional Requirements for Wisconsin Licensed/Medicare-Certified Home Health Agencies portion of the General Information section of this handbook.

Example of the physician orders: The staffing schedule on the Home Care Assessment Form shows a personal care worker (PCW) is needed two hours a day Monday through Friday. Orders should state:
"PCW for bathing, grooming, and dressing – two hours per day, five days per week," (written as 2h/d x 5d/w).

Prior Authorization Request Form

- Providers are required to submit a Prior Authorization Request Form (PA/RF) for services requiring PA. Refer to Appendix 8 for instructions on how to complete a PA/RF.
- Only one PA/RF is approved per recipient, per provider for a specific time period. Providers are required to request all prior authorized personal care services for a recipient on one PA/RF.
- The PA/RF should indicate the number of hours per week multiplied by the number of weeks requested (e.g., written as 10hr/wk x 52wk). This allows some flexibility in the schedule of service and reduces the need for PA amendments. For examples of PA/RF forms, refer to Appendix 9 (requesting DMS), Appendix 10 (requesting PRN hours), Appendix 11 (requesting personal care and home health services), Appendix 12 (requesting personal care-only services for a shared case), and Appendix 13 (requesting personal care-only services by one provider).

Examples of flexibility follow:

√ Although physician orders may be needed for additional hours on Monday, a PA amendment is not required because the weekly total will not be exceeded due to additional hours the family is able to provide on Saturday.

√ Housekeeping activities could be completed in one visit, if the recipient agrees, instead of being spread out over the week. However, limitations, as described in the Covered Services section, apply.

- The total hours requested on the PA/RF is required to match the number of hours on the physician's orders or the POC.
- Providers are required to submit the *original* PA/RF. Facsimiles will not be accepted. Each PA/RF must have the unique, preprinted seven-digit PA number that appears in red at the top of the original PA/RF. The number identifies the service on the billing claim form as a service that has been prior authorized and must be used for claim submission on all claims.
- Dually certified agencies are required to request personal care, home health aide, and part-time, intermittent skilled nursing services on one PA/RF. Refer to Appendix 11 for an example of a PA/RF for requesting personal care and home health services. Home health agencies can also refer to the Home Health Handbook for more information.

Obtaining Prior Authorization Forms

The PA/RF, Wisconsin Medicaid Home Care Assessment Form, and Wisconsin Medicaid Home Care Assessment Update Form can be obtained by writing to the following address:

Medicaid Form Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Use the following guidelines when obtaining forms:

- Please specify the form requested and the number of forms needed.
- Save reorder forms, which are included in the mailing request with each request form for future use.
- Do not request forms by telephone.

The Wisconsin Medicaid Home Care Assessment Form and its Update Form are also located in appendices 2 and 3 and may be photocopied.

HCFA 485, 486, and 487 forms may be obtained by:

- Photocopying or printing your own supply of the forms. Reproducible forms are available in appendices 5, 6, and 7.
- Purchasing the forms from a supplier of federal forms.
- Contacting the Medicare fiscal intermediary if you are a Medicare-certified

Providers are required to submit the *original* PA/RF. Facsimiles will not be accepted.

provider. Refer to Appendix 4 for instructions on how to complete all three HCFA forms.

Submitting Prior Authorization Requests

Providers are required to send completed PA request forms to:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

Providers should submit PA requests no earlier than 62 days prior to the requested grant date to decrease the likelihood that the recipient might not require the service by the time the grant date is reached. Refer to Appendix 14 for a checklist to ensure that you have the correct documentation with your PA request. Questions on PA requests that have already been submitted should be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

Providers should submit PA requests no earlier than 62 days prior to the requested grant date to decrease the likelihood that the recipient might not require the service by the time the grant date is reached.

Prior Authorization for Disposable Medical Supplies

Required Prior Authorization Forms

To obtain PA for DMS, personal care providers are required to submit the following completed documentation to Wisconsin Medicaid:

- A physician's prescription dated within six months of receipt by Wisconsin Medicaid, including specific information on frequency of use and expected duration of use.
- A completed Prior Authorization Request Form (PA/RF). Refer to Appendix 8 for instructions on how to complete the PA/RF for DMS and Appendix 9 for an example of a PA/RF for DMS.
- A Prior Authorization Durable Medical Equipment Attachment (PA/DMEA) form. This is the form used by personal care providers when requesting DMS. Refer to Appendix 15 for instructions on how to complete the PA/DMEA form and Appendix 16 for a PA/DMEA form which can be photocopied.

Obtaining Prior Authorization Forms

The PA/RF and PA/DMEA forms can be obtained by writing to the following address:

Medicaid Form Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Use the following guidelines when obtaining forms:

- Please specify the form requested and the number of forms needed.
- Save reorder forms, which are included in the mailing request with each request form for future use.
- Do not request forms by telephone.

Submitting Prior Authorization Requests

Providers are required to send completed PA request forms to:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

Questions on PA requests that have already been submitted should be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

Requesting PRN Hours

PRN travel time may be requested as needed to correlate with the PRN personal care hours.

Reasons for PRN Hours

PRN (which originated from the Latin term *pro re nata* and translates to "as needed") hours may be requested when there is a reason to expect a deviation from the typical weekly schedule of staffing as documented on the Home Care Assessment Form (HCAF).

PRN travel time may be requested as needed to correlate with the PRN personal care hours.

PRN Guidelines

- PRN hours must meet general PA criteria and be for a Medicaid-covered service.
- PRN services for a change in condition are usually granted only when the recipient has a demonstrated history of need for PRN services.
- The reason for PRN hours must be indicated on the physician's orders.

Initial Requests for PRN Hours

Providers should take the following steps to make an initial request for PRN hours:

1. Obtain a physician's order for PRN hours.

   Physician orders must be based on recipient needs **and** specify the circumstances when the hours may be used.

   Example: The staffing schedule on the Wisconsin Medicaid Home Care Assessment Form shows a personal care worker (PCW) is needed two hours a day Monday through Friday. You expect PRN visits to the physician may be necessary up to three times per year. Orders should state:

   "PCW for bathing, grooming, and dressing – two hours per day, five days per week (written as 2h/d x 5d/wk) AND three hours PRN to accompany client to doctor appointments."

2. Request PRN hours on the Prior Authorization Request Form (PA/RF).

   When requesting PRN hours on the PA/RF, request a specific number of PRN hours over the length of the entire PA period, not in per-week or per-month frequency. If the PCW must make additional trips to the recipient's home for the PRN hours, the provider may also request travel time to accommodate the additional PRN hours.

   Example: Your request should state (see Appendix 10 for an example of a PA/RF for PRN Hours):

   "W9900 – PCW 10 hours per week for 52 weeks and three hours PRN (written as 10hr/wk x 52wk and 3 hr PRN)."

   "W9902 – 2.5 hours travel time per week for 52 weeks and 1.5 hours travel time PRN (written as 2.5hr TT/wk x 52wk and 1.5hr TT PRN)."

Additional Requests for PRN Hours

If all the PRN hours granted on the initial PA have been used and there is reason to expect that more PRN hours may be necessary, the provider should take the following steps:

1. Obtain updated physician orders specifying the number of, and reason for, additional PRN hours.
2. Include documentation on the PA amendment request to show why previously granted PRN hours were needed **and** the dates the previously approved hours were used.
3. Submit an amendment for additional PRN hours.

   Example: A situation presents itself where due to an exacerbation in the recipient's illness, visits to the physician were more frequent than anticipated. The physician's orders should state:

"Add three hours PCW to accompany recipient to physician appointments PRN."

Element 8 of the Amendment Request Form should read: "Due to exacerbation of illness, PCW accompanied client to the physician on 3-4-99, 3-16-99, and 4-1-99. Since the PA does not expire until 11-19-99, it is expected that three more PRN hours will be required to accompany the recipient to physician appointments before the expiration date on the PA. Request: W9900 – three hours PRN. W9902 – 1.5 hours PRN."

Documentation of PRN Hours in the Medical Record

According to HFS 106.02(9), Wis. Admin. Code, the provider is required to document the use of PRN hours in the medical record, including:

- What PRN services were provided.
- Why the services were provided.
- When the services were provided.
- How many PRN hours were used.

The provider is required to document the use of PRN hours in the medical record.

Case Sharing

Medically necessary services cannot be duplicative with respect to other services being provided to the recipient.

According to HFS 101.03(96m)(b)(6), Wis. Admin. Code, medically necessary services cannot be duplicative with respect to other services being provided to the recipient. When more than one provider shares a case, the agencies need to integrate that information in the recipient's plan of care and the agency's prior authorization (PA) request. The following information will assist providers who are sharing cases with other providers.

Provider Responsibility

When multiple providers are caring for a recipient or "case sharing," each provider:

- Is responsible for obtaining a separate PA for the services they will perform.
- Should obtain PA immediately so providers do not exceed the 50-hour threshold unknowingly.
- Should communicate and coordinate the PA request with other case-sharing providers to assure appropriate care and reimbursement.

If a case is shared with a home health (HH) agency providing home health aide visits, it is expected that the HH agency will include routine personal care tasks in addition to medically oriented tasks, thereby lessening the need for personal care worker(PCW) activity. Each day an initial HH aide visit can be up to four hours if medically necessary, with subsequent visits up to three hours in duration if medically necessary.

Physician's Orders/Plan of Care

To prevent returns, clarify the PA request, and expedite the PA process, each provider should indicate all of the following on the physician's orders/Plan of Care (POC):

- The total number of personal care hours that the recipient requires.
- The names of the providers that will be sharing the case.
- The hours that each agency will be providing care.

Example: After assessing the recipient, it is determined that the recipient requires the assistance of a personal care worker (PCW) two hours per day, three days per week for bathing, grooming, and dressing. Agencies A and B will be sharing the case. The agencies have discussed the POC and have decided that Agency A will provide two hours of service per day, two days per week, while Agency B will provide two hours of service per day, one day per week. The total number of hours to be provided by both agencies combined will be six hours per week.

Orders submitted by Agency A should state:

- "Two hours per day, three days per week of PCW is needed for bathing, grooming, and dressing. Case share with Agency B.

  "Agency A will provide two hours per day, two days per week. Agency B will provide the remaining hours."

Orders submitted by Agency B should state:

- "Two hours per day, three days per week of PCW is needed for bathing, grooming, and dressing. Case share with Agency A.

  "Agency B will provide two hours per day, one day per week. Agency A will provide the remaining hours."

Requesting Prior Authorization

When case sharing, each provider is required to complete all the appropriate information about other providers on the PA forms as indicated below:

The Prior Authorization Request Form (Element 18)

- List the number of hours per week you will provide care. As shown in

the example above, Agency A would request four hours per week multiplied by 52 weeks.

- Write "shared case with (name of the other provider). Total hours for all providers will not exceed total hours on POC." Refer to Appendix 12 of this section for an example of how to indicate a shared case on the Prior Authorization Request Form (PA/RF).

The Wisconsin Medicaid Home Care Assessment Form

- Complete all appropriate elements that provide information on other providers performing home care services, with attention to element 12.1.

If you do not provide complete information regarding case sharing or provide inconsistent information, Wisconsin Medicaid may return the PA request. If services are duplicated, Wisconsin Medicaid will recoup reimbursement.

If you do not provide complete information regarding case sharing or provide inconsistent information, Wisconsin Medicaid may return the PA request.

Other Funding Sources

Some Medicaid recipients may be eligible for services provided by programs funded by other sources such as Medicare, commercial insurance, the Community Options Program (COP, COP-Waiver), and the Community Integration Program (CIP 1A, CIP 1B, CIP II) .

Although approval of personal care PA requests is not affected by other funding sources, it is helpful to the PA reviewers to be able to see that the recipient's needs are being met. Providers may identify other funding sources by completing all applicable sections of the Home Care Assessment Form.

Providers are urged to obtain a Medicaid PA before providing services if they have any doubt other insurances will reimburse for the service. If commercial insurance or Medicare covers the requested services, providers are always required to bill those health insurances first, even when there is an approved PA from Wisconsin Medicaid.

Prior Authorization Effective Dates

Providers should carefully review all approved PAs when they receive their copy and make note of the expiration date.

All approved prior authorizations (PA) have a grant/start date and an expiration date indicated on the Prior Authorization Request Form (PA/RF).

Grant Date

- The "grant date" or "start date" of a PA is the first date the PA is effective.
- Providers should indicate the date they intend services to begin. This should be indicated on the blank space to the right of the provider's signature on the PA/RF. Refer to appendices 9 through 13 for examples of PA/RFs.
- If no grant date is requested, the grant date will be the date when the PA/RF was received by Wisconsin Medicaid.

Expiration Date

- The expiration date is the date through which services are prior authorized.
- Prior authorizations are granted for varying periods of time depending on the circumstances, but are never granted for more than a 12-month period. Expiration dates vary from one PA to another and do not automatically expire at the end of the calendar year.
- Providers should carefully review all approved PAs when they receive their copy and make note of the expiration date.

Prior Authorization Backdating

To ensure that recipients receive necessary care at the time they need it, Wisconsin Medicaid may backdate new prior authorization (PA) requests or amendments as long as all departmental criteria are met. Renewal requests cannot be backdated.

To ensure that recipients receive necessary care at the time they need it, Wisconsin Medicaid may backdate new prior authorization (PA) requests or amendments as long as all departmental criteria are met.

The provider is solely responsible for submitting PA requests in a timely manner. For maximum backdating, follow the guidelines in this section.

New Requests

An initial PA request may be backdated 14 calendar days from the date of receipt by Wisconsin Medicaid. For backdating to be authorized, both of the following criteria must be met:

- Backdating is specifically requested in writing on the PA request.
- The request includes clinical justification for beginning services without PA.

For reimbursement back to the start of care date, Wisconsin Medicaid must receive the request within 14 calendar days of the start of service.

Backdating in Extraordinary Circumstances

In the following cases, a PA request may be backdated for greater than 14 days, if applicable.

1. A court order or hearing decision requiring Wisconsin Medicaid coverage is attached.
2. The recipient is retroactively eligible. (Indicate in element 18, "Description of Service," on the Prior Authorization Request Form [PA/RF], that the service was provided during a period of retroactive recipient eligibility. To the right of the provider signature, show the actual date the service was provided.)

Returned Requests

A new PA request returned for additional information may be backdated 14 calendar days from the date it was initially received by Wisconsin Medicaid if the additional corrected information is returned with the original PA/RF.

Amendment Requests

- Prior authorization amendment requests may be backdated 14 calendar days from the date of receipt by Wisconsin Medicaid if the request is for extraordinary circumstances such as emergency services or other services in which medical necessity could not have been predicted.
- Amendment requests may also be backdated to the grant date on the original PA request for the following two reasons:
  - √ The amendment request is directly related to a modification of the original request, AND Wisconsin Medicaid receives the amendment request within 14 calendar days of the adjudication date on the original PA/RF.
  - √ The amendment request results from an error on the original adjudication.

Denied Requests

Once a PA request has been denied, that PA number can no longer be used, and a new PA request must be submitted. A new request following a denial may be backdated to the original date the denied request was received by Wisconsin Medicaid when all the following criteria are met:

- The earlier grant date is requested.

- The denied PA request is referred to in writing.
- The new PA request has information to justify approval.

Renewal Requests (Exception to Backdating)

Renewal requests will not be backdated for continuation of ongoing services. To prevent a lapse in coverage, all renewal requests must arrive at Wisconsin Medicaid prior to the expiration date of the previous PA. Each provider is solely responsible for the timely submission of PA renewals.

To prevent a lapse in coverage, all renewal requests must arrive at Wisconsin Medicaid prior to the expiration date of the previous PA.

Amending an Approved Prior Authorization

When medically necessary, providers may submit an amendment to change or update a valid prior authorization (PA).

When the recipient is discharged, providers should send a PA amendment to terminate the PA.

Reasons for Amending a Prior Authorization

Amend a PA when:

- There has been a change in the recipient's condition requiring a change in level of care or frequency of hours of care. Physician orders that reflect the change are required.
- A provider reduces the quantity of services because a second provider begins to share the case. Requests for additional services by another provider may be denied if the number of hours on the first PA is not reduced at the same time.
- The provider discharges the recipient before the PA expires.

Prior Authorization Amendment Procedure for Discharged Recipients

When the recipient is discharged, providers should send a PA amendment to terminate the PA. This will facilitate the recipient's continuation of care. The provider should amend the expiration date of the PA to show the actual date of discharge. Refer to Appendix 20 of this section for an example of a PA Amendment Request Form showing discharge from services.

Reasons for discharge may include:

- More volunteer assistance becomes available.
- The recipient no longer needs personal care services. In this situation, you should retain physician's orders which recommend discharging the recipient.
- Another provider takes over personal care services for the recipient.
- The provider terminates participation in the Wisconsin Medicaid program.
- The recipient is admitted into an institution for a long-term stay.
- The recipient expires.

How to Amend a Prior Authorization

Amendments to an approved PA must be submitted on a PA Amendment Request Form. Providers amending PA requests are required to:

- Complete an Amendment Request Form describing the specific change requested and the reason for the request in sufficient detail that Wisconsin Medicaid can determine the medical necessity of the requested services. Refer to Appendix 17 for instructions for completion of the PA Amendment Request Form, Appendix 18 for a PA Amendment Request Form which can be photocopied, and Appendix 19 for an example of a PA Amendment Request Form.
- Attach a copy of the original approved Prior Authorization Request Form (PA/RF) to be amended.
- Submit a Home Care Assessment Form (HCAF) Update Form and any required attachments documenting the changes to the HCAF.
- Attach a copy of the updated Plan of Care (POC) or physician's orders. If current orders continue to be compatible with the new request, new orders are not necessary.
- Attach clinical or other supporting documentation.
- Submit the completed amendment request with any necessary attachments to Wisconsin Medicaid. For maximum backdating, Wisconsin Medicaid must receive the amended request within 14

calendar days of the date the amended services began.

Send amendment requests to:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

If you have questions regarding the amendment process, call Provider Services at (800)-947-9627 or (608)-221-9883.

If you have questions regarding the amendment process, call Provider Services at (800)-947-9627 or (608)-221-9883.

Prior Authorization Responses

Prior authorization (PA) requests may be returned, approved, modified, or denied by Wisconsin Medicaid.

Prior authorization (PA) requests may be returned, approved, modified, or denied by Wisconsin Medicaid. Providers should review the comments made by the Medicaid nurse consultant on the Prior Authorization Request Form (PA/RF) and take appropriate action. Providers are strongly encouraged to keep the recipient informed throughout the entire PA process.

Returned Prior Authorization Requests or Amendment Requests

A PA or amendment marked "returned" is not denied. There are normally two reasons why a PA is returned to you. Either there is an error on the submitted documentation or the information is incomplete. Prior authorization requests are returned to providers for both clerical and clinical reasons.

Common Clerical Reasons for Returns

Common clerical reasons for the return of PA requests are listed below:

- The recipient's primary diagnosis is missing.
- The required attachments have not been filled out correctly or are not included with PA requests.
- The physician's orders do not list required services in hours per day and days per week.
- The PA/RF request does not match physician's orders.
- The billing provider's name, address, or Wisconsin Medicaid provider number is missing or incorrect.
- The recipient is not eligible for Wisconsin Medicaid on the date Medicaid receives the PA request. Prior authorization is always contingent upon the recipient's eligibility on the date of service. Providers can use eligibility verification methods, such as the Automated Voice Response system, Provider Services, Dial-Up, and other products offered through a commercial eligibility verification vendor (for example, personal computer software or a magnetic stripe reader) to ensure the recipient is eligible for the requested dates of service.
- The recipient's name or the Wisconsin Medicaid identification number on the PA request does not match the name on file for the given Medicaid number. Be sure to use the recipient name and Medicaid identification number exactly as they appear on the Medicaid identification card.

Common Clinical Reasons for Returns

Common clinical reasons for the return of PA requests are listed below:

- Clinical information supplied on the PA attachment was not detailed enough to verify the medical necessity for the requested service.
- Clinical information is outdated.
- There is discrepancy from previous PAs or PAs submitted by other disciplines and providers.

Providers will recognize that a PA has been returned by one of two ways:

- The PA/RF is returned to the provider with the "return" box marked with instructions for the provider.
- The Amendment Request Form is returned with the appropriate return message indicated.

How to Respond to Returned Prior Authorization Requests or Amendments

After receiving a returned PA request, resubmit the original PA request with corrected information. It is important to return the

original PA request with the internal control number/date-stamp as this will allow maximum backdating.

Approved Prior Authorization Requests and Amendments

Providers will recognize that Wisconsin Medicaid has approved a PA if a copy of the PA/RF is returned with:

- The "approved" box marked.
- The grant and expiration dates indicated.
- A dated Medicaid analyst/consultant signature.
- A specific quantity of services indicated.

Prior authorization requests are approved for a specific frequency and duration of the services. Frequency is the number of hours per day, multiplied by the number of days per week. Duration is the number of weeks from the PA grant date through the expiration date. Providers may not use PA services more often than the frequency approved.

Modified Prior Authorization Requests and Amendments

Wisconsin Medicaid modifies PA requests when the requested hours exceed what Medicaid guidelines indicate are medically necessary. Some services may be approved, but at least one service is changed. The change could be for the number of hours per day, the number of days per week, or the level of care granted.

Providers will recognize that Wisconsin Medicaid has modified a PA if a copy of the PA/RF is returned with:

- The "modified" box marked with an explanation.
- The grant and expiration dates indicated.
- A dated Medicaid analyst/consultant signature.
- A specific quantity indicated.

How to Respond to a Modified Prior Authorization Request

If the PA or amendment was modified, the provider should discuss the modifications with the recipient/family and the physician to determine how the authorized hours could be best utilized. If the provider still has questions about a modified PA or amendment request, he or she can:

- Contact Provider Services, which will answer questions or direct providers to a Wisconsin Medicaid professional consultant for further clarification.
- Request reconsideration by submitting an amendment request with additional documentation that supports the original request. The amendment request should be received within 14 calendar days of the adjudication date on the original PA/RF or amendment. If the amendment request is approved, Wisconsin Medicaid will notify the provider of the effective date.
- Assist the recipient in his or her appeal efforts if the recipient elects to appeal the modification. Refer to the Fair Hearing Process portion of this section for more information.

Denied Prior Authorization Requests or Amendments

Wisconsin Medicaid denies personal care PA requests when:

- The services requested do not meet Wisconsin Medicaid PA guidelines.
- The services requested are not Medicaid-covered services under the personal care program.
- The medical necessity for the hours requested is not supported by information submitted in the Home Care Assessment Form.

Providers will recognize that Wisconsin Medicaid has denied a PA request if a carbon copy of the PA/RF is returned with:

Prior authorization requests are approved for a specific frequency and duration of the services.

- The "denied" box marked with an explanation comment or code.
- A dated Medicaid analyst/consultant signature.

How to Respond to a Denied Prior Authorization Request or Amendment

If the PA or amendment was denied, the provider should discuss the denied request with the recipient/family and the physician to determine all alternatives.

If the PA or amendment was denied, the provider should discuss the denied request with the recipient/family and the physician to determine all alternatives. If the provider still has questions about a denied PA or amendment request, he or she can:

- Contact Provider Services, which will answer questions or direct providers to a Medicaid professional consultant for further clarification.
- Request reconsideration by submitting a new PA request including additional documentation to support the request. The new PA should be received within 14 calendar days of the adjudication date of the original PA request or amendment to obtain maximum backdating. If the new PA request is approved, Wisconsin Medicaid will notify the provider of the effective date.
- Assist the recipient in his or her appeal efforts if the recipient elects to appeal the denial. Refer to Fair Hearing Process, below, for more information.

Fair Hearing Process

According to HFS 104.01(5), Wis. Admin. Code, the *recipient* has the right to appeal PA and amendment modifications and denials through the fair hearing process. Recipients are notified in writing by Wisconsin Medicaid of the PA modification or denial, their right to appeal, and an explanation of the appeal process.

Please refer to the All-Provider Handbook for further clarification on appeal procedures.

Glossary of Common Terms

Adjudication
Adjudication is when Wisconsin Medicaid makes a determination on a prior authorization request.

Backdating
Backdating occurs when prior authorization (PA) is given for effective dates prior to the PA request being received by the Wisconsin Medicaid fiscal agent.

Department of Health and Family Services (DHFS)
The Wisconsin Department of Health and Family Services administers Medicaid. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

Disposable medical supplies (DMS)
Disposable medical supplies are medically necessary items, which have a very limited life expectancy and are consumable, expendable, disposable, or nondurable.

Dually certified
An agency that is Medicaid-certified to provide both home health and personal care services is dually certified.

Licensed practical nurse (LPN)
A licensed practical nurse is a person who is licensed in Wisconsin as a practical nurse under ch. 441, Wis. Stats., or, if practicing in another state, is licensed as a practical nurse by that state.

Medical necessity
Medical necessity is a medical assistance service under ch. HFS 107, Wis. Admin. Code, that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability, and:
(b) Meets the following standards:
1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability.
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided.
3. Is appropriate with regard to generally accepted standards of medical practice.
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient.
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature.
6. Is not duplicative with respect to other services being provided to the recipient.
7. Is not solely for the convenience of the recipient, the recipient's family or a provider.
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service, which is reasonably accessible to the recipient.
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Medicare
Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Part-time, intermittent skilled nursing and therapy services
Skilled nursing and therapy services provided in the home for less than eight hours in a calendar day are part-time, intermittent.

Personal care worker (PCW)
A personal care worker is an individual employed by a personal care provider certified under HFS 105.17, Wis. Admin. Code, or under contract to the personal care provider to provide personal care services under the supervision of a registered nurse.

Plan of Care (POC)
A written plan of care for a recipient is developed by a registered nurse based on physician orders in collaboration with the recipient/family, and approved by the physician. The purpose of the POC is to provide necessary and appropriate services, allow appropriate assignment of a PCW, set standards for personal care activities, and give full consideration to the recipient's preferences for service arrangements and choice of PCWs. The POC is based on a visit to the recipient's home and includes a review and interpretation of the physician's orders; evaluation of the recipient's needs and preferences;

assessment of the recipient's social and physical environment, including family involvement, living conditions, the recipient's level of functioning and any pertinent cultural factors such as language; and the frequency and anticipated duration of service.

Prior authorization (PA)
Prior authorization (PA) is approval of coverage of Wisconsin Medicaid services granted by the Department of Health and Family Services (DHFS) before the provision of the services.

Private duty nursing (PDN)
Private duty nursing is a service provided by a registered nurse (RN) or licensed practical nurse (LPN) to a recipient who requires eight or more hours of skilled nursing care in a calendar day, as specified in HFS 107.12, Wis. Admin. Code.

PRN (from the latin term *pro re nata*)
PRN hours are "as needed" hours, which may be requested when there is a reason to expect a deviation from the typical weekly schedule of staffing as documented on the Home Care Assessment Form.

Provider
A personal care provider is a home health agency, county department, independent living center, tribe, or public health agency that has been certified by Wisconsin Medicaid to provide personal care services to recipients and to be reimbursed by Wisconsin Medicaid for those services.

Registered nurse (RN)
A registered nurse is a person who holds a current Wisconsin certificate of registration as a registered nurse under ch. 441, Wis. Stats., or, if practicing in another state, is registered with the appropriate licensing agency in that state.

Respiratory care services (RCS)
The treatment of a person who receives mechanically assisted respiration is a respiratory care service.

Supervision
Supervision of personal care services is required to be performed by a qualified RN who reviews the Plan of Care (POC), evaluates the recipient's condition, and observes the PCW performing assigned tasks at least every 60 days. Supervision requires intermittent face-to-face contact between supervisor and assistant and regular review of the assistant's work by the supervisor according to HFS 101.03(173), Wis. Admin. Code. Supervisory review includes:

- A visit to the recipient's home.
- Review of the PCWs daily written record.
- Discussions with the physician of any necessary changes in the POC, according to HFS 107.112(3)(c), Wis. Admin. Code.

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